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ABSTRACT

This report of a panel discussion focuses on the design, rationale, and evaluation of the Adolescent Crisis Unit for Treatment and Evaluation (ACUTE), a program of crisis intervention for young adolescents. An overview of the structure of ACUTE's clinical program describes the efficiency of the program in seeing referrals at the time of crisis, and outlines the treatment involving collaboration with other community agencies. ACUTE's staff is multi-disciplinary and includes social workers, a clinical psychologist and a child psychiatrist. The model underlying ACUTE's approach is presented as an integration of six theories: (1) crisis intervention: (2) brief, task-oriented treatment: (3) psychoanalysis: (4) network/systems: (5) family systems: and (6) Stierlin's dialectical theory. ACUTE's ongoing evaluation research program is discussed, along with some of the methodological and practical difficulties of conducting research in a community setting. (Author/NRB)

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CRISIS INTERVENTION FOR YOUNG ADOLESCENTS: THEORY, PRACTICE, AND RESEARCH

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Introduction: Robert A. Horwitz, Ph.D. (Chair).

I. "Structure of a Family-Oriented Crisis Intervention Program for Adolescents"--Theodore Zanker, M.D.

II. "A Theoretical Model for Family-Oriented Crisis Intervention"--Carl B. Cutchins, M.S.W.

III. "A Follow-Up Study of Adolescents Seen in Crisis Intervention"--Robert A. Horwitz, Ph.D.

IV. "Research in Community Settings: Methodological and Practical Limitations"--Ana Mari Cauce, M.S.

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CRISIS INTERVENTION FOR YOUNG ADOLESCENTS: THEORY, PRACTICE AND RESEARCH

General Summary

Despite increasing public awareness of the need for psychological services for youth, young adolescents continue to be an underserved population in this country (Lipsitz, 1977). Excluded as too young from adult psychiatric clinics and seeing themselves as too old for child guidance clinics, early adolescents in crisis often "fall through the cracks" of the mental health service delivery system and wind up served by no one. In New Haven, CT, an innovative program has been established to respond to the largely unmet needs of these young people, and the design, rationale, and evaluation of this program will be described in this panel.

ACUTE, the Adolescent Crisis Unit for Treatment and Evaluation, is a joint project of a general hospital and a child guidance clinic, and is organized and staffed specifically to provide intensive crisis intervention and brief treatment to 11-to 15-year-olds and their families. The kinds of crises which come to ACUTE's attention include suicide gestures, violent behavior, drug abuse, psychotic episodes, school avoidance, and runaways from home.

The participants in this discussion will first provide an overview of the structure and theoretical underpinnings of ACUTE's clinical program, then describe the agency's ongoing evaluation research program and some of the methodological and practical difficulties encountered in conducting research in a community setting. Illustrative case material will be presented, and discussion from the audience will be encouraged.

CRISIS INTERVENTION FOR YOUNG ADOLESCENTS: THEORY, PRACTICE, AND RESEARCH

I. Structure of a Family-Oriented Crisis Intervention Program for Adolescents.

ACUTE is a crisis intervention, family-oriented, outpatient and inpatient program for young adolescents, aged 11-15, who are in acute emotional crisis. A joint project of the Clifford Beers Guidance Clinic and the Hospital of St. Raphael, it is housed in its own office space directly across the street from the hospital emergency room and gets many of its referrals from the emergency room, as well as from private pediatricians, schools, police departments, the juvenile court, the State Department of Children and Youth Services, and other mental health facilities.

Even though the cases which present at ACUTE are all in acute emergency and involve serious degrees of psychopathology, most are treated on an outpatient basis. The reason this is possible is that staff, on rotation, are available 24 hours a day, 7 days a week, for telephone or in-person consultations, and regular treatment sessions are scheduled with unusual frequency for an outpatient clinic: three to four visits per week, sometimes even more. In some cases, such as serious suicide attempts or psychotic episodes, a three-day inpatient hospitalization is available, after which patients either enter outpatient treatment at ACUTE or are transferred to longer-term hospitals.

In order to keep staff members available to accept new crisis cases without delay (families are usually seen for their initial appointment within hours of being referred), treatment must neces-

sarily be kept brief: no more than 30 days. Since treatment begins at a time of crisis, however, family and intrapsychic dynamics are often quite exposed, and motivation to work towards change is relatively high. Substantial improvement thus occurs quite rapidly in many cases, though follow-up treatment to consolidate gains is often recommended.

Treatment at ACUTE involves a combination of family and individual therapy and close collaboration with other community agencies involved in the adolescent's life, including the school and, when necessary, the police and juvenile court. ACUTE's staff is multi-disciplinary, with three full-time social workers, a full-time clinical psychologist, and a half-time child psychiatrist, and while only one staff member is assigned to any given case, staff work closely with each other to provide mutual support and consultation.

The presentations which follow will describe the theory behind ACUTE's approach and research currently in progress.

CRISIS INTERVENTION FOR YOUNG ADOLESCENTS: THEORY, PRACTICE, AND RESEARCH

II. A Theoretical Model for Family-Oriented Crisis Intervention.

The theoretical model underlying ACUTE's clinical program is based on an integration of six sometimes contradictory schools of thought: 1) crisis intervention theory; 2) brief, task-oriented treatment theory; 3) psychoanalytic theory; 4) network/systems theory; 5) family systems theory; and 6) Stierlin's dialectical theory.

From the crisis intervention literature (Lindeman, 1944; Caplan, 1964; Rapoport, 1962; Pittman, 1973, etc.), we understand crises to be time-limited phenomena which evidence themselves through a marked decline in coping skills, following a precipitating event which is experienced as overwhelming. Rapid intervention is believed to be helpful in returning an individual or family to its previous level of functioning, preventing maladaptive response patterns from becoming fixed forms of interaction, allowing diagnostic assessment to occur before significant defenses are mobilized, and enabling the clinician to "lend his ego" to the family until the stress of the crisis subsides.

From the brief, task-oriented treatment literature, we borrow the ideas of condensing the natural process of therapy, setting priorities, and providing structure to facilitate problem-solving (Mann, 1973; Reid & Epstein, 1972).

Psychoanalytic theory helps us understand the psychic structures of individual family members and the process of therapy itself. Defense mechanisms, ego structures, resistance, transference and counter-

transference are typical of the psychoanalytic concepts we utilize regularly.

Also integral to our approach is understanding the role that other systems--i.e., schools, medical facilities, court, welfare etc. - - play in the lives of adolescents and their families. Dealing with the interface of these social systems is crucial to our work, and for that we rely heavily upon network/systems theory.

Because of ACUTE's emphasis on understanding the adolescent's problems in a family context, we also draw extensively from family systems theory, particularly that of Minuchin (1974). Adolescent symptons are understood as serving a function in the social system of the family, helping to maintain a homeostatic balance. Family theory concepts such as generational boundaries, detour of conflict, subsystem alliances, etc. are central to our understanding of the meaning and function of the crisis within the family.

Finally, another point of view which informs and guides our work is the dialectical process model of Helm Stierlin (1974), which emphasizes the interplay between the developmental issues of adolescence and the sometimes conflicting developmental issues of parents. According to Stierlin's theory, adolescent behavior problems often reflect difficulties shared by the adolescent and his parents in handling the process of separation, and this view certainly coincides with our own.

CRISIS INTERVENTION FOR YOUNG ADOLESCENTS: THEORY, PRACTICE, AND RESEARCH

III. A Follow-Up Study of Adolescents Seen in Crisis Intervention

One of the frustrations of working in a time-limited brief treatment program is not knowing how effective one's interventions have really been in the long run. Since ACUTE's inception in 1970, there has been a strong interest in conducting a formal follow-up study to assess systematically how our ex-patients are functioning and how they recall and perceive the helpfulness of our program. This part of our panel discussion will describe the design of a follow-up study which was undertaken during the past year and is still in progress.

By early 1979, more than 1800 families had been through ACUTE's treatment program, and since it would not be feasible to contact all of them, it was decided to look closely at all the cases admitted during a single fiscal year, 1977-78. A coding form was devised to extract large quantities of data from the patients' charts, including demographic data (family income, size, racial/ethnic group, parents' educational level, rural/urban, history of divorce/remarriage, etc.), diagnosis, presenting problems, crisis-precipitating factors, number of treatment sessions, degree of therapist-judged improvement, etc. In addition, letters were sent out to parents of all adolescents who were seen in four or more treatment sessions, asking their permission to let us interview the adolescents to find out how they have been doing since being seen at ACUTE. A semi-structured interview was designed to probe for level of functioning and adjustment in school, with peers, at work (if employed), and with parents and other family members. The interview also asked the adolescents to recollect their

treatment at ACUTE and comment how they feel it affected them, their parent(s), and their family relationships. Following completion of the interview, the adolescents were sent a packet of three standardized questionnaires: a modified version of the Weissman (1976) Social Adjustment Scale, the Moos (1976) Family Environment Scale, and Kovacs (1978) Childhood Depression Inventory. Parents were also asked to complete the Family Environment Scale (to allow for comparison of different family members' perceptions of current family functioning), and the Achenbach (1978-79) Child Behavior Checklist.

Among the questions the research is attempting to answer are: 1) how well, as a whole, are adolescents previously seen in crisis intervention doing in various aspects of their lives; 2) are there predictable differences in functioning among socio-economic and/or diagnostic groups; and 3) do adolescents who present with behavioral problems which clinically seem to be "masking" a depression actually show evidence of depression on a standardized scale?

Preliminary findings from this research will be presented and discussed.

CRISIS INTERVENTION FOR YOUNG ADOLESCENTS: THEORY, PRACTICE, RESEARCH

IV. Research in Community Settings: Methodological and Practical Limitations

A glaring problem with community out-patient programs in general, and crisis programs for adolescents in particular, has been inadequate research and evaluation. This situation has developed, in part, because of the often unavoidable conflict between providing good treatment and insuring rigorous experimental control for good research. The present work discusses the theoretical and practical difficulties encountered in setting up a research program in the context of a treatment setting such as ACUTE. Some of the general methodological issues discussed are:

1) Whom To Study and What to Measure.

Given the family orientation at ACUTE, it was difficult to decide where to focus our change-measures: the adolescent or the family. Clearly improvement in the "identified patient" is the long-term goal of any intervention; however, it also seemed reasonable to expect changes elsewhere in the family. One problem encountered was how to assess in depth both the adolescents and their families, given the limited time and manpower available for research within a service agency. In the end we chose to interview the adolescents but gather information on family functioning primarily through questionnaires. One rich source of information about the family was the detailed summaries written by the ACUTE clinicians. Nonetheless, we were still faced with the dilemma of how to extract data from these records in a quantified form.

2) The Problem of the Control Group.

One frequent criticism of studies evaluating psychotherapy is that they do not show that improvement, if it did occur, was caused by the clinical intervention. Proving this would require a no-treatment control group. However, obtaining such a group for research purposes would necessitate witholding treatment from adolescents in acute crisis. This clearly could not be done for ethical reasons. Therefore, the focus of our study had to be shifted away from a controlled evaluation study to a more open-ended follow-up of post-discharge functioning.

3) The Issue of Timing.

For how long, and even if, any changes should occur after a 30-day intervention is questionable. If a research study is conducted right after treatment ends, one might expect to find the maximum amount of change; however, one cannot gauge how stable and lasting such change will be. Yet, if one waits too long it may be presumptuous to assume that any changes are even minimally related to the treatment. In the ACUTE study, we chose to conduct the follow-up near enough to treatment that one could reasonably expect that impact of the intervention was still being felt, yet, far enough away that changes found would not be just fleeting. Still, the conclusions of such a study apply to the time frame used, and one can only speculate about the shorter-or longer-term effects of treatment.

Other practical issues involved in conducting research in community settings that will be addressed in this presentation are: re-contacting adolescents and their families in a highly mobile urban community; obtaining a high enough return-rate on questionnaires to lend validity to data analysis; designing measures that adequately deal with a variety of family organizations (intact, single-parent, reconstituted etc.); and finding ways to involve the agency's clinical staff in the research and to utilize their knowledge about the subject population.

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